Toll Free: 1-800-894-3754

PO Box 45561
Olympia, WA 98504-5561

ACCIDENT QUESTIONNAIRE

PATIENT'S NAME	PATIENT'S IDENTIFICATION NUMBER

The agency has processed a bill submitted by for for services on for the above named person. We are required by law to determine if any other insurance resources are available. Failure to return this form completed within 30 days may jeopardize your Medicaid benefits WAC 388-505-0540(4).

Please complete the following:

DATE OF INJURY	TYPE OF INJURY RECEIVED	PATIENT'S HOME TELEPHONE NUMBER

Cause of Injury (check one): ➡	☐ Work Related (Complete Sections A & D)	☐ Fall ☐ Assault ☐ Other: _____ (Complete Sections B & D)	☐ Motor Vehicle (Complete Sections C & D on back)

☐ IF NOT AN INJURY OR ACCIDENT, COMPLETE SECTION D ON BACK.

SECTION A - (WORK RELATED)

EMPLOYER'S NAME	ALLOWED INJURY	DATE OF INJURY	CLAIM NUMBER

☐ Claim is open ☐ Claim is closed Date closed:

NAME AND ADDRESS OF INSURANCE COMPANY

NAME AND ADDRESS OF PATIENT'S ATTORNEY FOR THIS ACCIDENT	ATTORNEY'S TELEPHONE NUMBER

SECTION B - (FALL, ASSAULT, OTHER)

Patient was (check one): ☐ Guest ☐ Customer ☐ Other (specify):

ACCIDENT LOCATION: STREET ADDRESS	CITY	STATE	COUNTY

NAME OF PROPERTY OWNER	INSURED'S NAME

STREET ADDRESS OF PROPERTY OWNER	CITY	STATE	ZIP CODE

INSURANCE COMPANY'S NAME	POLICY NUMBER	CLAIM NUMBER

INSURANCE COMPANY'S ADDRESS	CITY	STATE	ZIP CODE	TELEPHONE NUMBER

NAME OF PATIENT'S ATTORNEY FOR THIS ACCIDENT	ATTORNEY'S TELEPHONE NUMBER

ATTORNEY'S ADDRESS	CITY	STATE	ZIP CODE

SECTION C - (MOTOR VEHICLE ACCIDENT)

ACCIDENT LOCATION: STREET ADDRESS, CITY, STATE AND COUNTY (ATTACH COPY OF ACCIDENT REPORT, IF AVAILABLE)

PATIENT WAS (CHECK ONE)
☐ Driver ☐ Passenger ☐ Other: _____

OTHER FAMILY MEMBERS INVOLVED IN ACCIDENT

WHO WAS CITED IN THE ACCIDENT
☐ Driver of vehicle 1 ☐ Driver of vehicle 2 ☐ Other: (specify)

NAME AND ADDRESS OF PATIENT'S ATTORNEY FOR THIS ACCIDENT

ATTORNEY'S TELEPHONE NUMBER

☐ Open/pending Claim ☐ Settled Claim, if settled, give date:

DATE OF INJURY

VEHICLE #1

DRIVER'S NAME

DRIVER'S ADDRESS

INSURANCE COMPANY'S NAME

TELEPHONE NUMBER

INSURANCE COMPANY'S ADDRESS

INSURED MOTORIST'S NAME

INSURED MOTORIST'S ADDRESS

INSURANCE POLICY NUMBER

CLAIM NUMBER

☐ Liability coverage ☐ Personal injury protection coverage

VEHICLE OWNER'S NAME

VEHICLE OWNER'S ADDRESS

VEHICLE #2

DRIVER'S NAME

DRIVER'S ADDRESS

INSURANCE COMPANY'S NAME

TELEPHONE NUMBER

INSURANCE COMPANY'S ADDRESS

INSURED MOTORIST'S NAME

INSURED MOTORIST'S ADDRESS

INSURANCE POLICY NUMBER

CLAIM NUMBER

☐ Liability coverage ☐ Personal injury protection coverage

VEHICLE OWNER'S NAME

VEHICLE OWNER'S ADDRESS

SECTION D

Describe how the injury or accident occurred. If this was not an injury or accident please explain why you sought medical treatment for the condition listed on the other side.